STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525719	A. BUILDING _____ B. WING _____	C 11/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WI VETERANS HM AINSWORTH 800	N2665 CTY RD QQ KING, WI 54946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 29173 This was a recertification and self-report survey conducted at Wisconsin Veterans Home - Ainsworth Hall from 11/02/15 to 11/09/15. # of federal citations issued: 2 The most serious citations were F225 and F314, cited at a scope/severity level of D (potential for harm/isolated). Census: 195 Sample size: 30 Supplemental sample size: 3 Survey coordinator: #29173	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 225	Continued From page 1 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 29173 Based on record review and staff interview, the facility did not ensure all alleged violations involving potential abuse, mistreatment, neglect, or injuries of unknown source were reported immediately and thoroughly investigated for 1 (member #27) of 30 members reviewed for abuse. Member #27 was found to have a bruise to the left inner mid thigh. The facility did not thoroughly investigate member #27's injury of unknown origin in attempt to ensure abuse had not occurred. Additionally, the facility did not immediately report the bruise to the State Survey and Certification Agency.	F 225		

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F 225	Continued From page 2	F 225		

Findings include:

The facility's Member Abuse, Neglect, Mistreatment, of Property, and Injuries of Unknown Source policy and procedure, revised in August 2015, stated the purpose of the policy is to protect member's rights to be free from abuse, neglect, misappropriation, and mistreatment. Injury of unknown source is defined as an injury that occurs to a client where the source of the injury was not observed or could not be explained by the member and is suspicious because of the extent of the injury or location or number of injuries overtime or on occasion...All observed, noted, or otherwise reportable incidents shall be reported as follows: Clinical staff: report to RN (Registered Nurse) or supervisor immediately. Other than clinical staff: Report to the RN, a nursing supervisor or the building executive Director/designee. This must be reported immediately. Examples of events which must be reported include suspicious bruising of residents, or occurrences, patterns, and trends that may constitute abuse...The facility shall report all incidents meeting regulatory criteria according to DQA (Division of Quality Assurance) Memo 11-032 to DQA (as soon as possible, not to exceed 24 hours from discovery of the incident), and complete a final report within 5 working days of the incident.

On 11/04/15, surveyor #29173 reviewed the medical record of member #27. The face sheet dated 5/6/15, contained within the medical record indicated member #27 was admitted with diagnoses to include dementia and hypertension.

Member #27's most recent MDS (Minimum Data Set) assessment dated 8/4/15, indicated member

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F 225	Continued From page 3 #27 had severe cognitive impairment and required extensive assistance from staff for bed mobility, transfers, and ADL's (Activities of Daily Living). Member #27's medical record included "Physician Orders and Progress notes", dated 6/7/15 that documented: "Monitor bruise to left inner thigh (mid thigh) everyday until resolved..." The TAR (Treatment Administration Record) for Member #27 dated 6/7/15, indicated "monitor bruise to left inner mid thigh daily." Member #27's medical record did not include additional documentation regarding the member's bruise. On 11/5/15 at 3:10 p.m., during daily exit with the facility staff, surveyor #29173 interviewed DON (Director of Nursing)-A and NHA (Nursing Home Administrator)-B regarding member #27's left inner mid thigh bruise noted on 6/7/15. NHA-B verified staff did not report the bruise of unknown origin to the nursing supervisor. DON-A and NHA-B indicated RN-C had observed member #27's bruise, but did not report to the nursing supervisor or the NHA. DON-A stated, "RN-C just added the bruise to member #27's TAR to monitor and failed to document or report the bruise." NHA-B stated the bruise should have been immediately reported, an investigation started and self report submitted to the State. NHA-B indicated education of staff was initiated after surveyor #29173 reported the injury.	F 225		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 4	F 314		

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Surveyor: 14108

Based on observation, record review and staff interview, the facility did not ensure that 1 (member #10) of 15 sampled members reviewed for pressure ulcer treatment, interventions and risk received appropriate care to promote healing and/or prevent pressure ulcers from developing.

Member #10 was assessed to be at high risk for the development of pressure ulcers. Member #10 had a significant weight loss identified on 8/2015. Multiple observations of member #10's heels in full contact with the mattress were made. In addition, member #10's care plan did not include interventions to prevent the development of pressure ulcers to member #10's heels.

Findings include:

The Quick Reference Guide entitled "Pressure Ulcer Prevention" published by the National Pressure Ulcer Advisory Panel in 2009 indicated to prevent pressure ulcers in individuals considered to be at risk for the development of pressure ulcers, ensure the heels are free of the

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F 314	Continued From page 5	F 314		

surface of the bed. Heel protection devices should elevate the heels completely (offload them) in such a way as to distribute the weight of the leg along the calf without putting pressure on the Achilles tendon. Using a pillow under the calves so the heels are elevated (i.e., "floating") will accomplish reduction of pressure on heels.

Member #10's Diagnoses List included multiple diagnoses to include Parkinson's and dementia.

The Podiatry note dated 3/24/15, documented member #10 had a history of edema. The Podiatrist's assessment documented member #10's dorsal pedis pulse and posterior tibial pulse on both feet were 0/4 with CFT (capillary filling time) of less than 2 seconds. Member #10 showed decreased tone, decreased temperature, decreased turgor and decreased elasticity of the skin.

Member #10's care plan for impaired skin integrity (Braden Score - High Risk) dated 7/8/15, did not include an approach for the protection of member #10's heels to prevent the development of pressure ulcers. Member #10 has a small opening on the coccyx called a sacral dimple that is identified as congenial, but has a risk for infection.

Member #10's most recent Braden dated 9/21/15, had a score of 6 (very high risk for the development of pressure ulcers), which was a decline from the Braden score of 9 on 6/28/15, and a decline from the Braden score of 10 on 3/30/15.

Member #10's most recent MDS (Minimum Data Set) assessment dated 9/25/15, documented

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F 314	Continued From page 6	F 314		

member #10 had a score of 5/15 on the BIMS (brief interview mental status). The lower the score the cognitive impairment. The assessment also documented member #10 required extensive assistance for two staff members for bed mobility.

Member #10's weight was reviewed and noted from 4/2015 to present, member #10's weight went from 152 pounds to 135.6 pounds. Member #10 is followed by the Dietician and changes have been made to the member's diet.

On 11/4/15 from 10:30 a.m. to 11:15 a.m., surveyor #14108 observed member #10 lying in bed with both heels in full contact with the alternating air mattress. The cushion used to elevate both heels off the mattress was located in a space between the end of the mattress and the foot board of the bed. At 11:15 a.m., CNA (Certified Nursing Assistant)-F and CNA-G entered the room to assist the member out of bed. At 11:20 a.m., surveyor #14108 interviewed both CNAs regarding the green cushion between the mattress and the foot board of the member's bed. CNA-F indicated the cushion was used to position the member from side to side, heels up or whatever is needed. Both CNAs indicated member #10 was cooperative with cares and interventions for positioning. CNA-F commented member #10 has refused the use of the splint.

On 11/5/15 at 9:40 a.m., surveyor #14108 observed member #10 lying in bed with a pillow positioned under the member's left side to elevate it off of the mattress. A pillow was positioned between the member's knees and calves. Member #10's left heel was in full contact with the mattress and the outer right ankle was also in full contact with the mattress.

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F 314	Continued From page 7	F 314		

On 11/5/15 at 3:02 p.m., surveyor #14108 observed member #10 lying in bed with both heels in full contact with the mattress. At 3:05 p.m., surveyor #14108, RN (Registered Nurse)-D and RN-E observed member #10's heels in full contact with the mattress. Both RN-D and RN-E verified the member's heels should be off loading or free floating to prevent the development of pressure ulcers. At this time surveyor #14108 reviewed member #10's care plan located in the member's room and noted off loading and/or elevating the member's heels off the mattress was not included on the care plan. RN-E stated the intervention of free floating member #10's heels should be on the care plan.

On 11/5/15 at approximately 3:10 p.m., during the observation of member #10's heels in full contact with the mattress, RN-D removed the member's TED hose to observed the heels. Both heels were noted to be a persistent reddish/pink in color, and were blanchable when assessed by RN-D. RN-D and RN-E verified the persistent reddish pink color on the member's heels was located in the area where each heel had been in contact with the mattress.

On 11/5/15 at approximately 3:20 p.m., surveyor #14108, RN-E and RN-D reviewed the information documented in the Podiatry note dated 3/24/15. Both RNs verified this would place member #10 at greater risk for the development of pressure ulcers if the heels were not off loaded or provided pressure relief when in bed.

On 11/5/15 at 3:43 p.m., surveyor #14108 reviewed the above observations, interviews and record review with DON (Director of Nursing)-A.

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F 314	Continued From page 8	F 314		

DON-A verified member #10 should have both heels elevated off the mattress for the prevention of pressure users. DON-A indicated based on member #10's Podiatry note, the member has characteristics of either peripheral vascular or arterial issues in the lower extremities, and it is the facility's standard to address the prevention of pressure ulcers to the heels. DON-A indicated the facility follows the National Pressure Ulcer Advisory Panel as their standard of practice.

On 11/9/15 at 9:58 a.m., surveyor #14108 interviewed RN-D regarding member #10. RN-D indicated Heel Medix Boots were placed on both of member #10's feet, and that member #10 was accepting of the boots and the boots were working well.

On 11/9/15 at 10:05 a.m., surveyor #14108 and RN-D interviewed CNA-F regarding member #10. CNA-F indicated she assisted member #10 into bed on Thursday 11/5/15 at approximately 1:00 p.m., as it was close to break time. RN-D reviewed the importance of turning member #10 when in bed related the member's declines and losing weight. CNA-F indicated that at times when asked, member #10 would decline to have feet free floated with a pillow. CNA-F indicated when a pillow was placed between member #10's legs, the heels would still rest on the mattress. CNA-F indicated not informing the nurse that the member refused to free float heels. CNA-F confirmed that the nurse should be informed so the nurse could assess the situation and look at alternative interventions. At 10:25 a.m., RN-D verified staff did not report member #10 refusing any interventions, including not free floating the member's heels.